PSY
PSYCHOLOGICAL
SERVICES, P.C.

JEROLD M. GRODIN, Ph.D., DIRECTOR

7 WELLS STREET SUITE 201 SARATOGA SPRINGS, NY 12866 TEL 518-587-4161 FAX 518 587-5134

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We, **PSYCHOLOGICAL SERVICES, P.C.,** assume that we may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. All reasonable requests will be approved. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as follows:

____ At my home telephone number: _____

____ At my work telephone number: _____

____ On my cell phone: _____

____ Other: _____

Please check your preferences:

	Home	Work	Cell
You can leave messages with detailed information…….	____	____	____
Leave message with call-back number only……	____	____	____
Call only at specific times of day: _____	____	____	____
May we say the practice name?.....	____	____	____
How should we identify ourselves?_____	____	____	____

Correspondence:

_____ My fax number(s): _____

_____ E-mail: _____@_____

If you wished to be contacted in writing to an address different than your home address, please specify:

_____ _____

Signature of Patient (or legal guardian) Date

_____

Print Name